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Peacekeeping and humanitarian assistance missions are increasing in frequency and importance in the post-Cold War era. The U.S. military is currently participating in major UN peacekeeping operations in Somalia (Operation Restore Hope) and the former Yugoslavia (Operation Provide Promise). While much is known about soldier stress and adaptation in more conventional military operations, the U.S. military has little experience with peacekeeping missions. How combat-trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute positively to such operations, to soldier health and well-being, and to military readiness of U.S. forces. Since October 1992, the U.S. Army in Europe has provided medical care for the 25,000 UNPROFOR (United Nations Protection Forces) soldiers located in the former Yugoslavia. The U.S. Army Medical Research Unit-Europe is conducting human dimensions research on soldier and family coping and adaptation in the medical and support units currently deployed in Croatia. Using a longitudinal approach, the research aims to identify and describe the key sources of stress before, during, and after the 6-month deployment. This project provides a model for conducting human dimensions research in military units deployed on contingency operations.
This paper was presented at the XIII International Sociological Association World Congress of Sociology, Bielefeld, Germany, July 1994.

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Social Psychological Issues in the Adaptation of a US Army Medical Unit to the UNPROFOR Mission[1]

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SUMMARY

Peacekeeping and humanitarian assistance missions are increasing in frequency and importance in the post Cold War era. The U.S. military is currently participating in major United Nations sponsored peacekeeping operations in Somalia (Operation Restore Hope) and the former Yugoslavia (Operation Provide Promise). While much is known about soldier stress and adaptation in more conventional military operations, the U.S. military has little experience with United Nations led peacekeeping missions. How combat trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute positively to such operations, to individual soldier health and well being, and to the overall military readiness of U.S. forces. Since October of 1992 as part of Operation Provide Promise, the U.S. Army in Europe has provided medical care for the 25 000 UNPROFOR (United Nations Protection Forces) soldiers located in the former Yugoslavia. The U.S. Army Medical Research Unit - Europe is conducting human dimensions research on soldier and family coping and adaptation in the medical and support units currently deployed in Croatia. Using a longitudinal approach, the research aims to identify and describe the key sources of stress before, during, and after the 6 month deployment. We are also assessing the impact of these stressors on soldier health, morale and cohesion, as well as identifying resources and coping strategies that contribute to resiliency and psychological well being in peacekeeping deployments. This project provides a model for conducting human dimensions research in military units deployed on contingency and peacekeeping operations, and yields empirical results for use in planning future contingency deployments in post Cold War Europe.

[1]Presented at the XIII International Sociological Association World Congress of Sociology, Bielefeld, Germany, July 1994. The views of the authors do not necessarily reflect those of the Department of the Army or the Department of Defense (para 4-3, AR 360-5).

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Social Psychological Issues in the Adaptation of a US Army Medical Unit to the UNPROFOR Mission

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Introduction

While much is known about soldier stress and adaptation in more conventional military operations, the U.S. military has little experience with United Nations peacekeeping missions. How combat-trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute positively to such operations. Since October of 1992 as part of Operation Provide Promise, the U.S. Army in Europe has provided medical care for the 25,000 UNPROFOR (United Nations Protection Forces) soldiers located in the former Yugoslavia. This paper reports preliminary results of a longitudinal investigation of "human dimensions" issues in an Army medical task force that deployed from Germany to Croatia for this U.S. mission in 1993.

Responding to the perceived value of "human dimensions" field research in major U.S. military operations such as the Gulf War, the Army's Office of the Surgeon General directed the U.S. Army Medical Research & Development Command to provide "Human Dimensions in Combat" research teams for future mobilizations and deployments ("Human Dimensions in Combat Research (HDCR) Mission", OTSG memorandum dated 9 July 1993). The mission of Human Dimensions in Combat Research Teams is: "In periods of mobilization, deploy with U.S. forces and perform observational research and consulting on topics of stress, coping, adaptation, morale and unit cohesion" (draft Memorandum of Understanding between Department of the Army Deputy Chief of Staff for Personnel and the Office of the Surgeon General, titled "Establishment of Human Dimensions in Combat Research Unit", undated). The U.S. Army Medical Research Unit - Europe (USAMRU-E) in Germany, a Special Foreign Activity of the Walter Reed Army Institute of Research, conducts behavioral science research on soldier and family stress and adaptation in a forward-deployed force. As U.S. Army forces in the post Cold War Europe assume more contingency and peacekeeping operations throughout the European theater and Africa, USAMRU-E has adapted the Human Dimensions in Combat Research concept to such operations.

In November of 1992, the U.S. Army was given the mission to provide medical support to the 25,000 United Nations peacekeeping forces operating in the former Yugoslavia (Operation Provide Promise). A Task Force of about 300 U.S. soldiers was dispatched from Germany for a 6-month deployment. USAMRU-E researchers collected pilot data from this unit on a variety of human dimensions issues. In March of 1993 another U.S. Army unit in Germany was identified as the next to deploy for this mission. Research with this second unit was more systematic and detailed, and is the basis for this report.

Method

Data collection began during the pre deployment phase. Over a two-week training period, 74 semi structured interviews were done, and 188 self-report surveys completed by soldiers. Extensive observations were also conducted. While the bulk of the interviews were individual, a few were done in small groups of 2 3 soldiers. Two teams of two persons each were used for this phase of the data collection. Also during the pre deployment period, investigators made observations at several key unit events, such as a command sponsored unit leader seminar, and the immediate pre deployment lock-in period and departure ceremony.

A two person Human Dimensions Research Team made four data collection site-visits to the unit in Croatia over the course of the deployment, staying for 7-10 days per visit. The first visit covered the initial arrival and transition period, with subsequent visits about 2-months and 3 1/2 months into the deployment. The third site visit utilized a larger research team of four members, and included administration of a "mid-deployment" survey. Usable surveys were obtained from 128 soldiers, or about 60% of the unit. The final visit was timed to occur near the end of the mission, about 2 weeks prior to return to Germany. A brief survey was administered at this point, with a usable N = 81. This represented about 50% of those available at that time. We also simultaneously conducted a detailed study of rear detachment and family issues, including spouse interviews and surveys. The unit returned to Germany in early October 1993. The content of surveys and interviews covered 3 general areas: items aimed at identifying (1)the sources of stress, (2)physical and mental health outcomes (including morale), and (3)individual and organizational factors that might influence responses (positive and negative) to stress.

Results

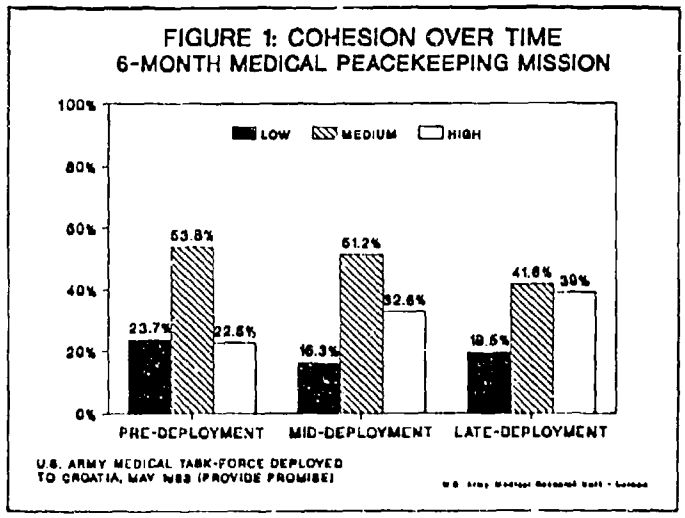
1. Stress: Overall, the major stress factor in the pre-deployment period was uncertainty associated with getting to know peers and leaders, and finding out who was going and when. There was substantial concern about the welfare of families during the separation, especially for soldiers drawn from outlying areas. This was frequently related to the loss of services in some communities as a direct function of the drawdown of Army forces in Europe. Soldiers rated their personal morale somewhat higher than unit morale in the pre-deployment period.

During the mid-deployment phase, a critical stress factor was the lack of meaningful activities to engage in. This was frequently described as "boredom." In fact, the patient load on the hospital was not severe, and travel restrictions prevented U.S. medical personnel from doing outreach and liaison work in any of the forward sectors. There was also a growing sense of isolation associated with the perceived lack of responsiveness of rear support elements to requests for supplies and replacement personnel. This was apparently exacerbated by a lack of media attention to the UNPROFOR medical support mission. For many of the married soldiers, concern for families back home was a major issue. Finally, many perceived an unfair distribution of resources, such as special U.N. pay, awards, supplies, and access to vehicles, leading to a sense of relative deprivation.

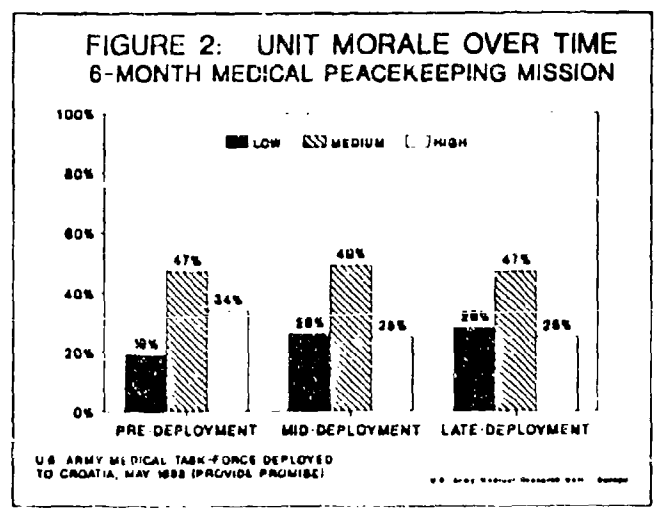
The key stressors in the final period, just 2-weeks before scheduled re-deployment to Germany, also had to do with uncertainty and ambiguity. The future basing of the unit was unknown, leaving many soldiers wondering where they would re-deploy to, and whether they would have to move their families. There was a continued sense of relative deprivation, and ambiguity about the mission itself and its value. While the opportunity to treat a small number of civilian "humanitarian" patients at the hospital was welcomed by the staff, it also led to increased questions about why more humanitarian medical care could not have been accomplished. During this period there was also an increased security threat, as nearby targets came under Serbian artillery attack. This clearly increased tension levels for a time, although it had some positive effects as well. It added a sense of realism to the environment, and the greater media attention that followed was generally welcomed by the soldiers. It may also have worked to increase unit cohesion, as soldiers labored together to strengthen perimeter defenses in the face of a common external threat.

2. Cohesion: Though built around an existing core element, this medical unit was specially constituted to serve the medical peacekeeping mission. Personnel for the unit, which increased in size from about 30 to about 200 people, were drawn mainly from two locations in Germany, with others coming from widely dispersed communities. The practice of assembling units that are specially tailored for a particular mission is increasingly common. Leaders face some special challenges in melding such disparate elements into cohesive and effective operational units. for the unit under study, this situation was extreme. There was considerable turmoil for the soldiers, many of whom were complete strangers to each other.

Also, many key leaders were new in their jobs and not known by the soldiers. A further complication was engendered by senior command disagreement on what the size of the unit should be in order to meet the mission. This critical question was not resolved unitl shortly before the actual deployment. This meant that in the pre-deployment period, many of the soldiers undergoing the training were unsure about whether they would actually be part of the mission.



Drawing on the survey data collected at the pre-deployment, mid-deployment, and late-deployment periods, Figure 1 displays rated unit cohesion levels over time. It is clear from this Figure that although a majority (53%) rated unit cohesion as moderate early on, few (22.5%) saw it as being high. Over time, those rating unit cohesion as high increased to 39%, but still relatively large groups saw unit cohesion as only moderate (41.6%) or low (19.5%). In interpreting these results it is important to remember that the medical support mission required a collection of specialized work sections with very different responsibilities, from clinical staff to motor pool workers to cooks to resupply technicians. The interview data reveal that cohesion levels were very high in some sections, but quite low in others. Further analyses will focus more on cohesion within work sections as the level of analysis. Clearly, an understanding of the influences on unit cohesion in newly organized task forces such as this one must include an examination of work section as well as unit level phenomena.



3. Morale: Figure 2 shows unit morale levels at three points in time, as rated by soldiers in the unit. It is clear that the proportion of soldiers rating morale as low increased over time, and those rating morale as high decreased. The interview

data reveal that initial levels were influenced in part by an excitement and enthusiasm for the special medical peacekeeping mission, and the "chance to make a difference". Lower levels over the course of the deployment were influenced by many factors, including the relative lack of meaningful work activity. The interview data also suggest that morale was preserved at reasonably high levels throughout partly as a function of the shared perception that key unit leaders were doing their best to care for soldiers, and keep them well-informed. Detailed analysis of the survey and interview data will identify more precisely the positive and negative influences on soldier morale, health and well-being.

This preliminary analysis of data collected during a U.S. Army peacekeeping deployment demonstrates the viability and value of conducting "Human Dimensions" research in contingency/peacekeeping operations. Such missions are becoming more common for the U.S. military, and the sources of stress on soldiers are not identical to those found in more traditional "combat" operations. Applying multiple data collection methods over time has allowed us to identify the key stressors at various phases of an entire operation, and begin to understand the factors that are influencing soldier morale and mental health. As the U.S. military forces shrink, the active utilization of deployable "Human Dimensions" research teams will help to assure optimized performance from our human resources.

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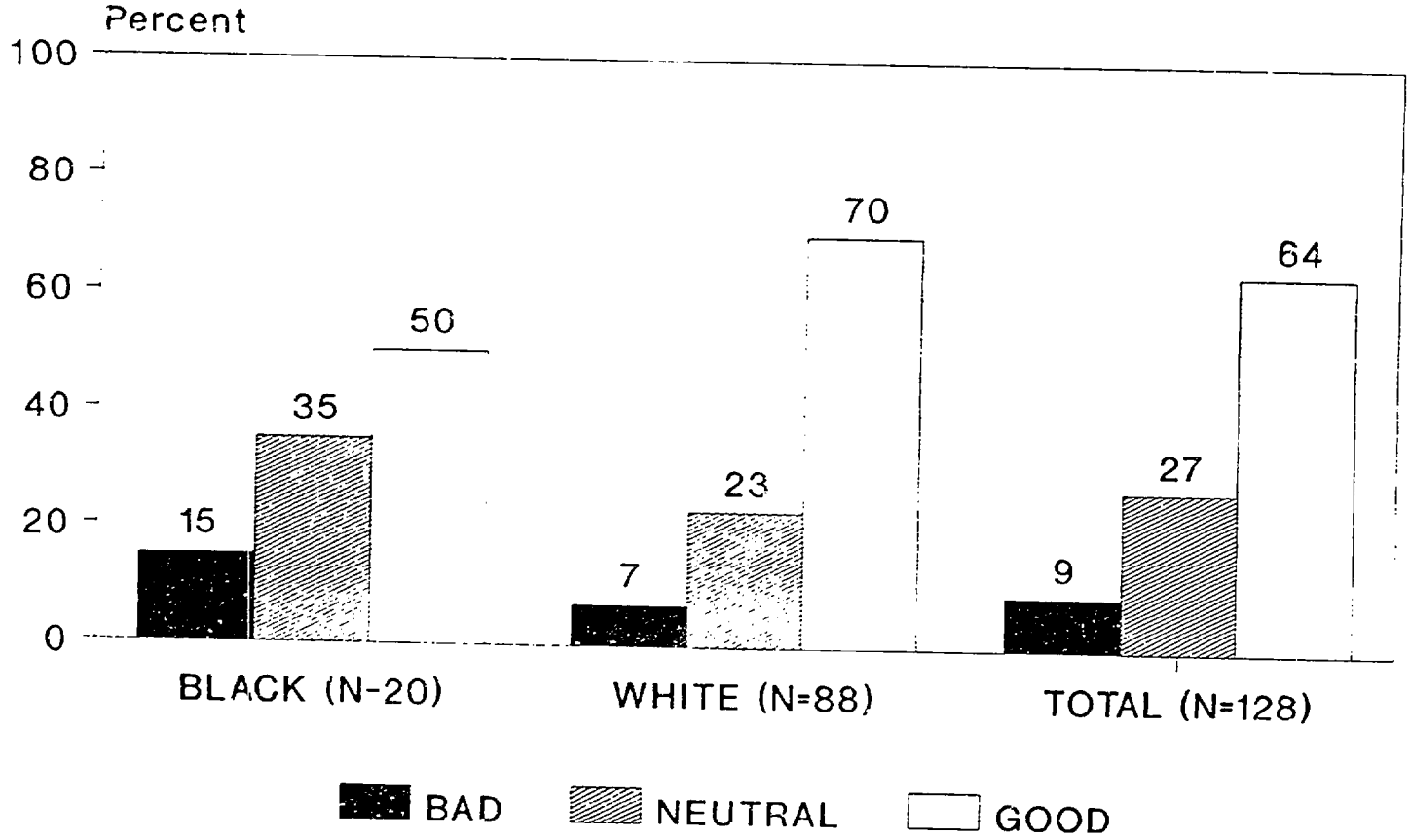
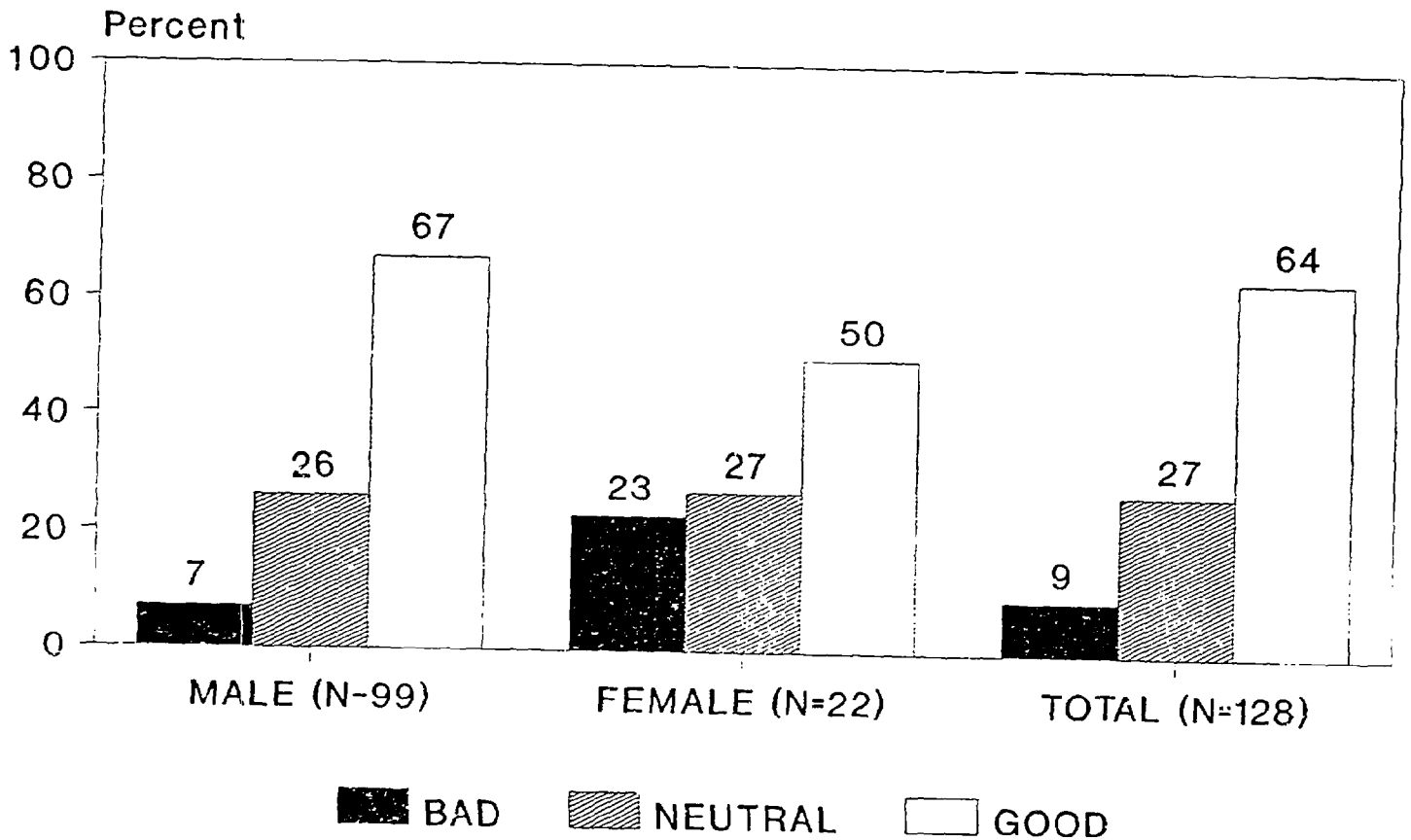
RELATIONS INSIDE THE UNIT
OFFICER-ENLISTED RELATIONS



AMERICAN SOLDIERS IN ZAGREB

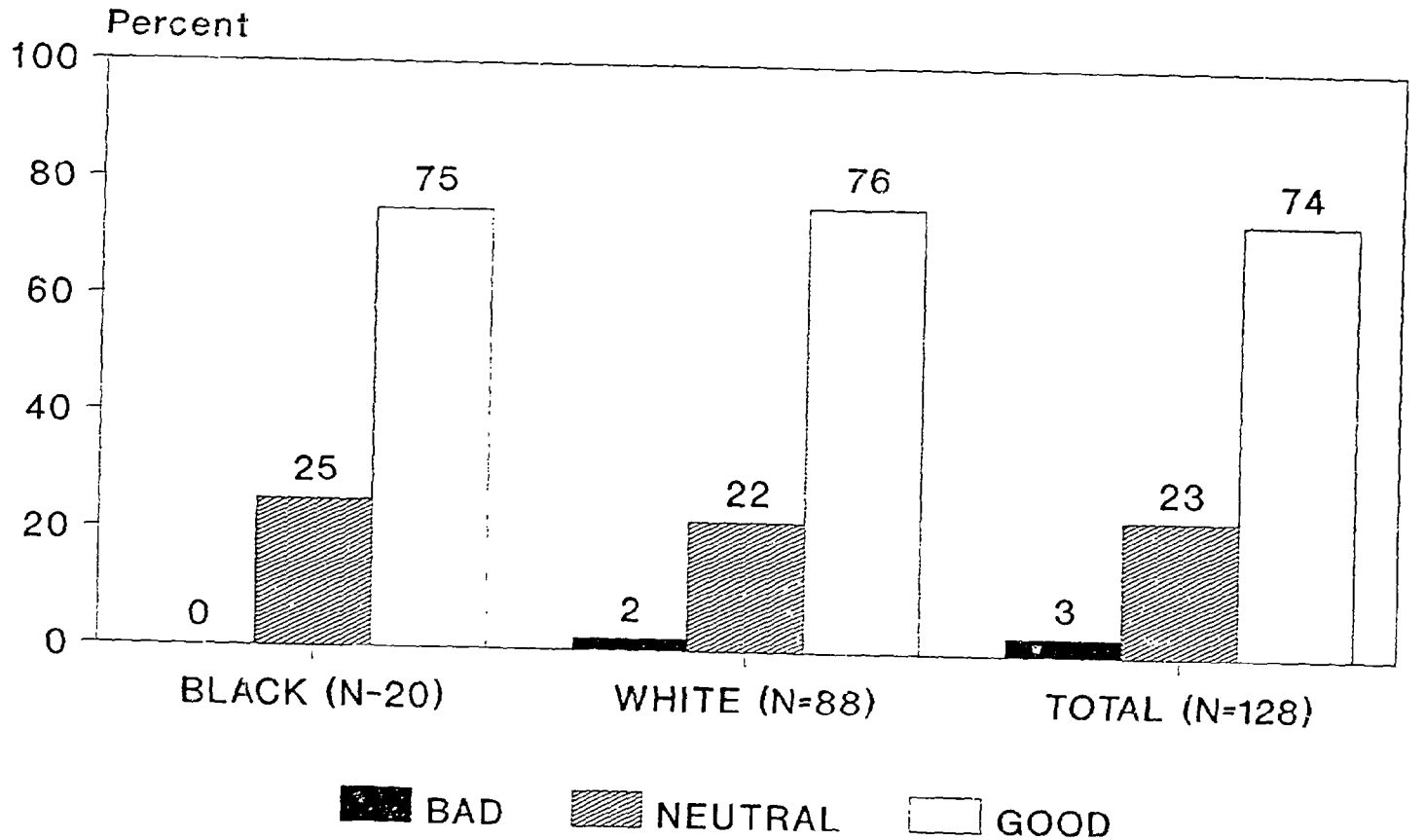
RELATIONS INSIDE THE UNIT

OFFICER-ENLISTED SOLDIER RELATIONS



AMERICAN SOLDIERS IN ZAGREB

RELATIONS INSIDE THE UNIT
BLACK-WHITE SOLDIER RELATIONS



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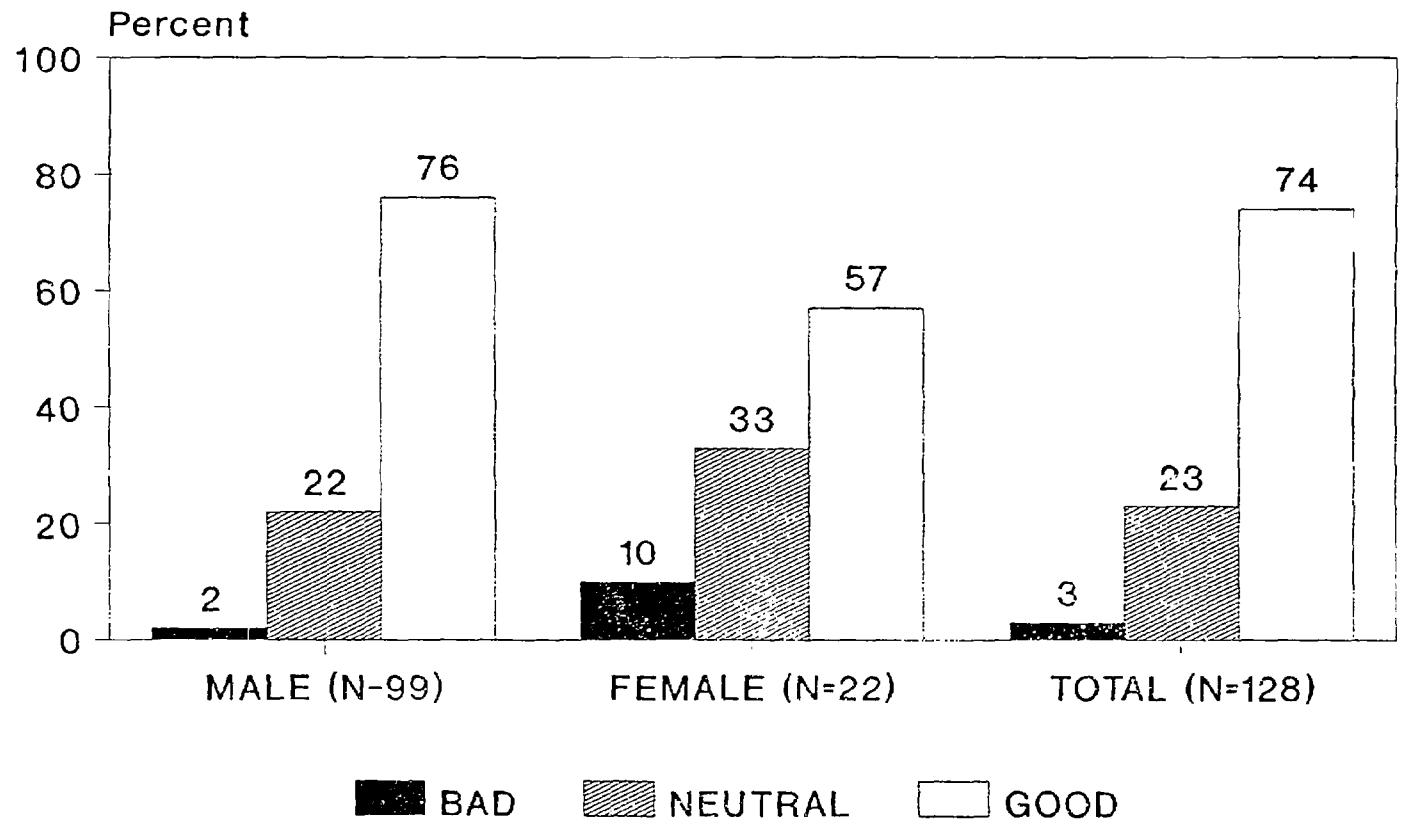
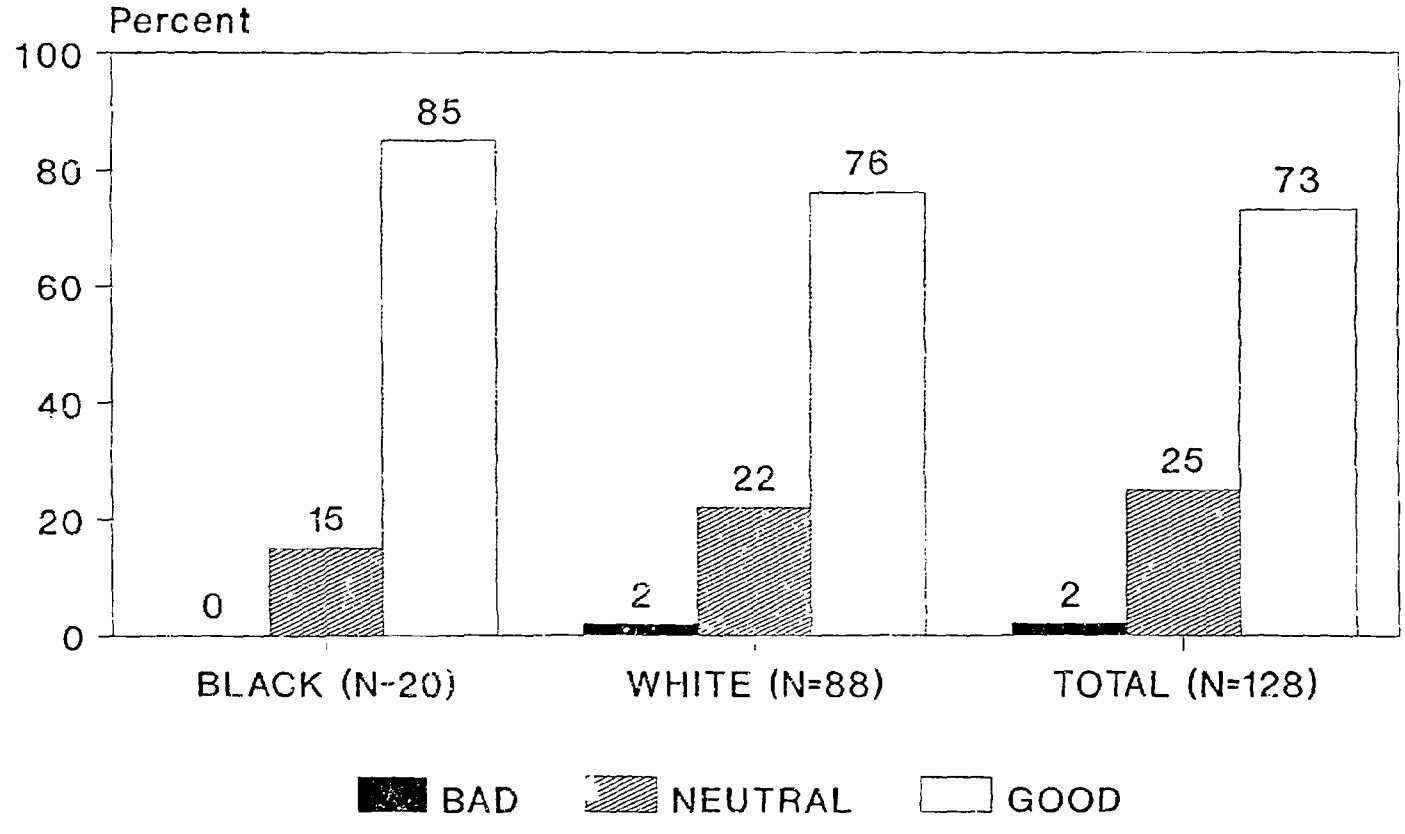
RELATIONS INSIDE THE UNIT
BLACK-WHITE SOLDIER RELATIONS



AMERICAN SOLDIERS IN ZAGREB

RELATIONS INSIDE THE UNIT

MALE-FEMALE SOLDIER RELATIONS



AMERICAN SOLDIERS IN ZAGREB

RELATIONS WITH LOCAL POPULACE AND OTHER UN FORCES
PERCENT RATING POSITIVE (+), NEUTRAL, NEGATIVE (-)

	TOTAL	BLACK	WHITE	MALE	FEMALE
CROATIANS	30+	35+	30+	32+	18+
	45	60	48	50	59
	25-	5-	22-	18-	23-
FRENCH	29+	60+	22+	31+	18+
	27	25	36	37	36
	44-	15-	42-	32-	46-
BRITISH	88+	95+	90+	86+	95+
	12	5	10	14	5
	0-	0-	0-	0-	0-
DUTCH	82+	90+	85+	81+	86+
	18	10	15	19	14
	0-	0-	0-	0-	0-
SUPPORT FROM UN	33+	32+	38+	32+	41+
	51	53	49	52	50
	15-	15-	13-	16-	9-